



Pediatric-Psychology Partnership for Abuse Prevention: Implications for Maternal and Child Health

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Abstract

Objectives: This poster describes the associations between lifetime exposure to violence and health-related findings from an integrated, collaborative training program within an ambulatory pediatric clinic.

Background: Pediatric clinics offer unique opportunities for integrating trauma-focused services as the visit often includes the female caregiver and the child, permitting conjoint assessment and intervention as well as discussion of the potential ways that the experience of violence may be affecting maternal or child behavioral health and/or parenting challenges.

Program Description: Pediatric-Psychology Partnership for Abuse Prevention (PPP-AP) was a 7-year-old federally funded project that used culturally competent psychology trainee-pediatric resident and medical trainee pairs for abuse prevention. Culturally competent intimate partner violence (IPV) screenings and safety planning were conducted with 1230 predominantly African-American, low income female caregivers. The project was expanded to include adolescents ($n = 141$), known as Pediatric-Psychology Partnership for Dating Violence Prevention (PPP-DVP). In addition, detailed assessments of maternal, self-reported depression and parenting practices and adolescent self-reported behavioral health concerns, symptoms of posttraumatic stress disorder (PTSD) and detailed dating violence experiences were obtained for 36 female caregiver-adolescent dyads.

Results: Nearly 1/3 of female caregivers reported lifetime histories of IPV and 1/3 of adolescents reported having witnessed violence. Data from a subset of the overall sample ($n = 69$) female caregivers revealed that past experiences of IPV were associated at the trend level with adolescents' past experiences of dating violence. More detailed assessment on the smaller sample of dyads ($n = 36$) revealed that adolescent's BMI was significantly and positively correlated with maternal concerns of their adolescent's internalizing and externalizing behaviors, maternal use of inconsistent discipline, adolescent symptoms of PTSD, dating violence experiences of physical abuse victimization, physical abuse perpetration, and psychological abuse perpetration. General somatic concerns such as headaches, dizziness, fatigue and stomachaches were significantly associated with dating violence victimization and perpetration and symptoms of PTSD and physical dating violence victimization and symptoms of PTSD were unique predictors of somatic distress.

Discussion and Recommendations: Implications for integrated pediatric violence and health prevention approaches are discussed.

Introduction

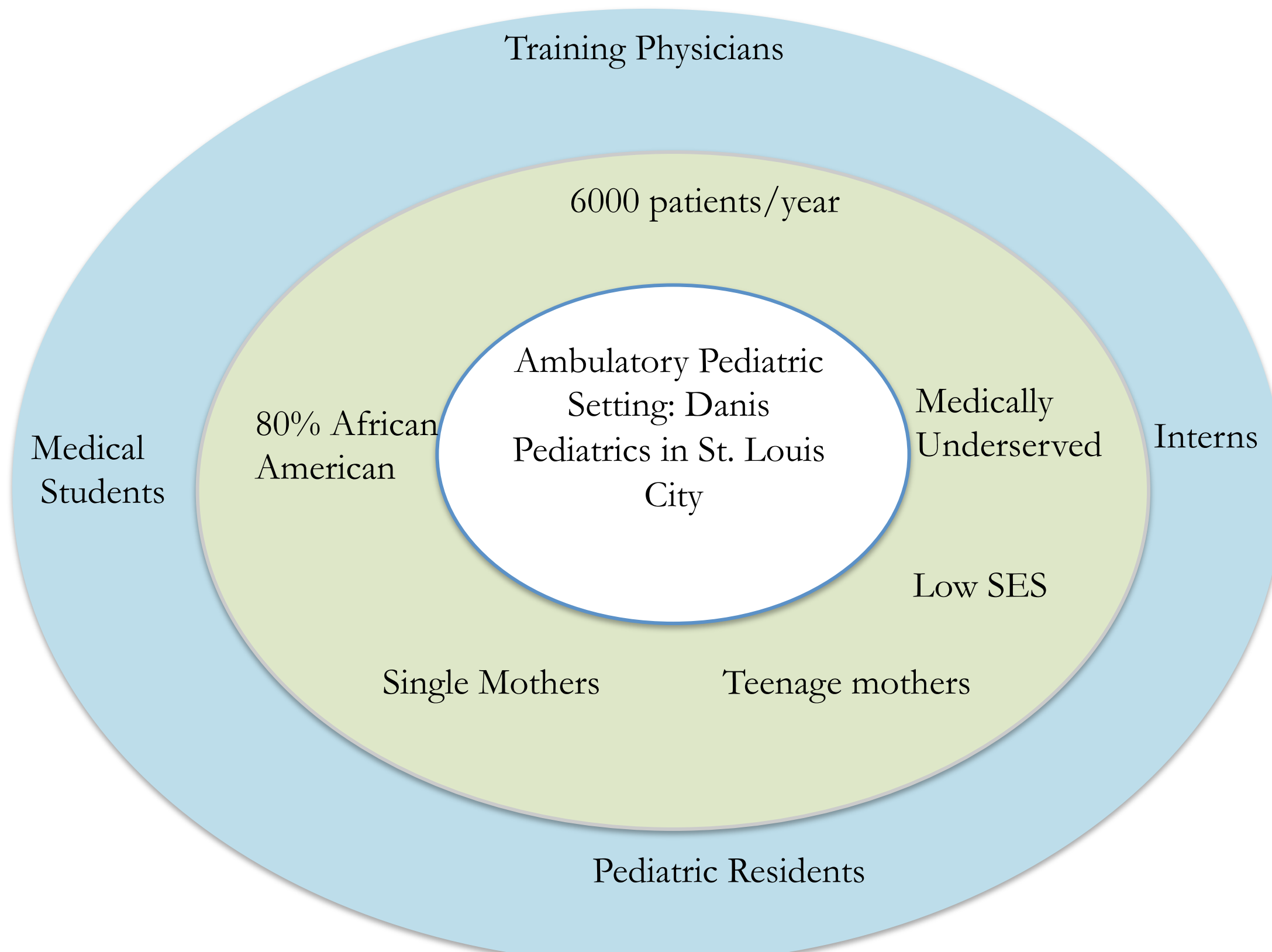
◆ Female caregivers report current experiences of intimate partner violence (IPV) ranging from 8.4% to 11% in pediatric settings (McCloskey et al., 2005).

◆ Adolescent exposure to dating violence has been associated with numerous negative health outcomes including injury as well as increased rates of risky sexual behavior, unhealthy dieting, episodic heavy drinking, attempted suicide, and physical fighting (MMWR, 2006).

◆ Adolescence comprises a critical window of opportunity for dating violence assessment and intervention. The assessment must encompass the unique features of teen dating violence, including experiencing multiple forms (e.g., physical, psychological, sexual) of violence within multiple contexts (e.g., at home, within the community, within dating relationships).

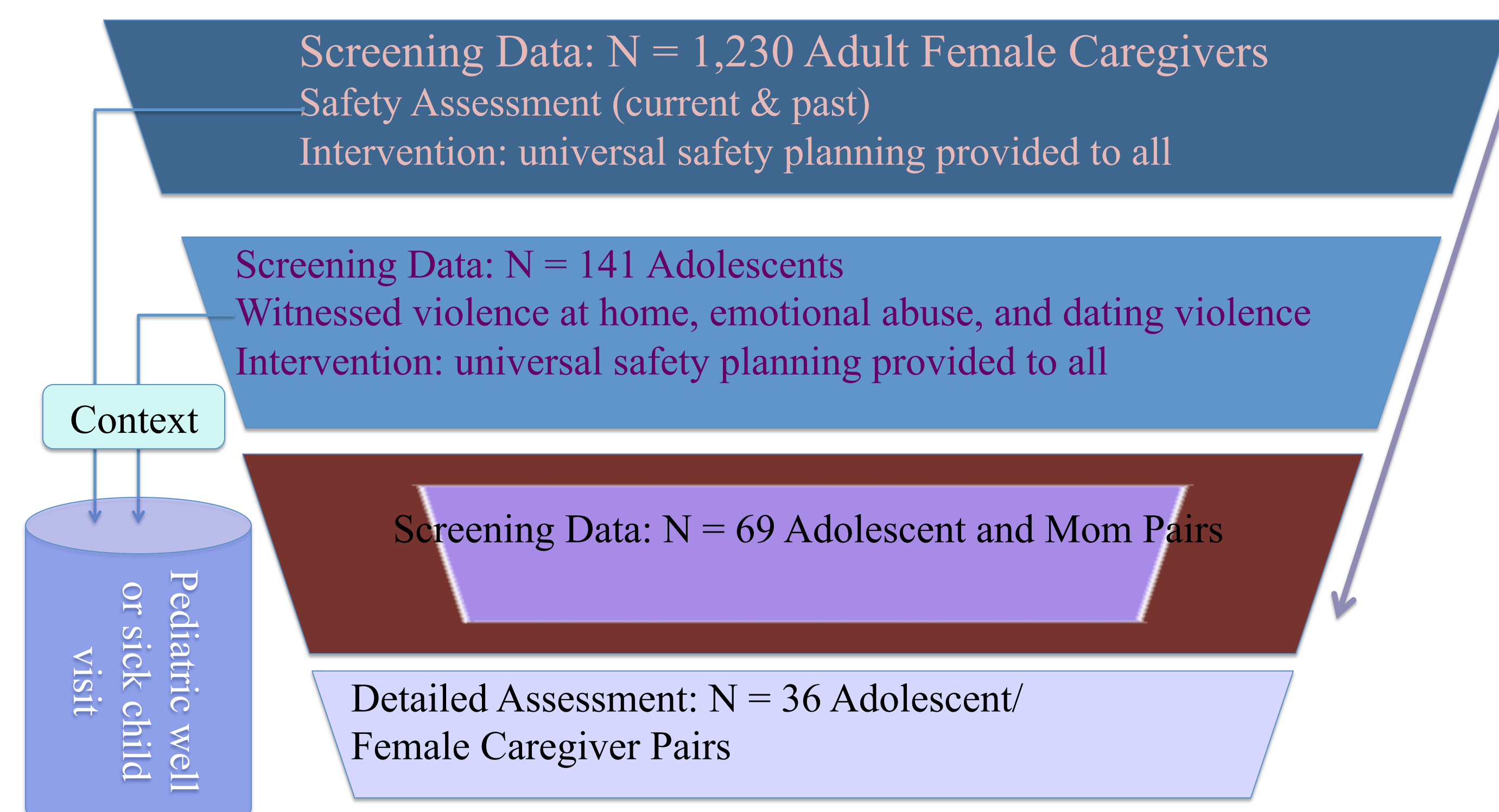
Setting

◆ Ambulatory Pediatric Clinic Located at Cardinal Glennon Children's Medical Center (Saint Louis University School of Medicine)



Methods

We are conducting safety screening with all moms within the clinic. When moms are being physically hurt or threatened, we know that this can impact the health and well being of them and their children. Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?



Selected Measures

Los Angeles Symptom Checklist (LASC) Foy, Wood, King, King, & Resnick (1997).

Items combined to create a PTSD symptom scale ($\alpha = .83$)

Items combined to create a Somatic distress symptom scale ($\alpha = .84$)

Youth Risk Behavior Survey

Centers for Disease Control (2007).

Items for height and weight used to calculate BMI.

Safe Dates Psychological/Physical Abuse: Perpetration/Victimization Scales

Foshee, Bauman, Arriaga, Helms, Koch, & Linder (1998)

Alabama Parenting Questionnaire- Shelton, Frick, & Wootton (1996)

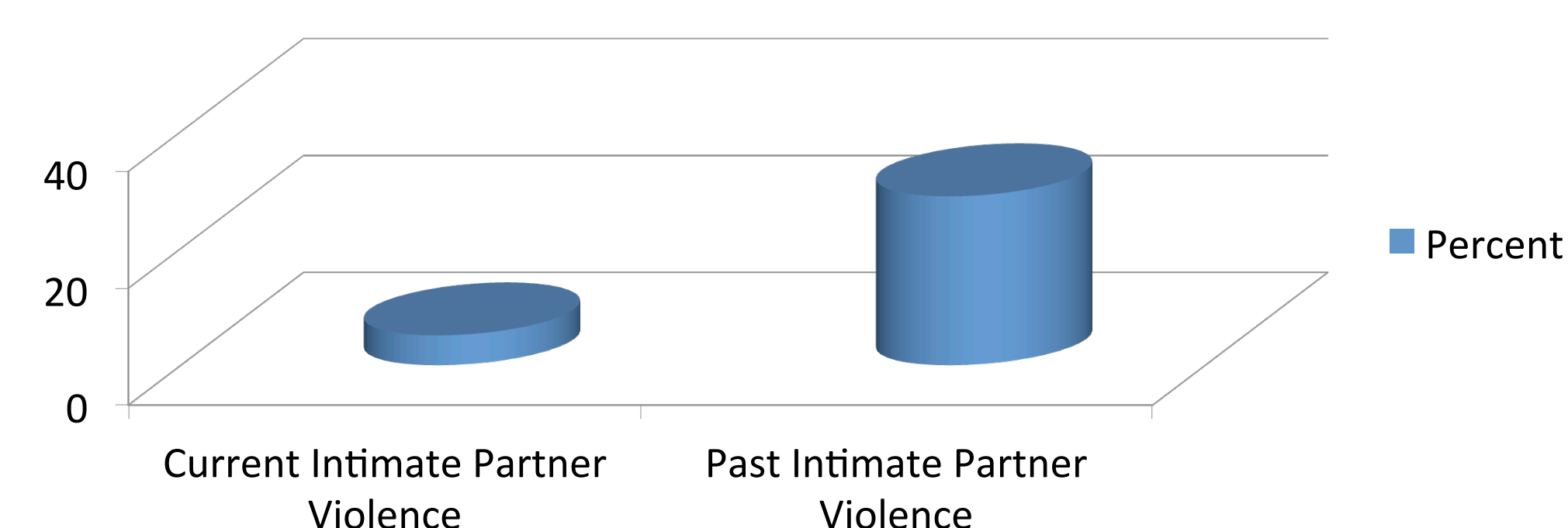
Pediatric Symptom Checklist - 17- Gardner et al. (1999)

Resources

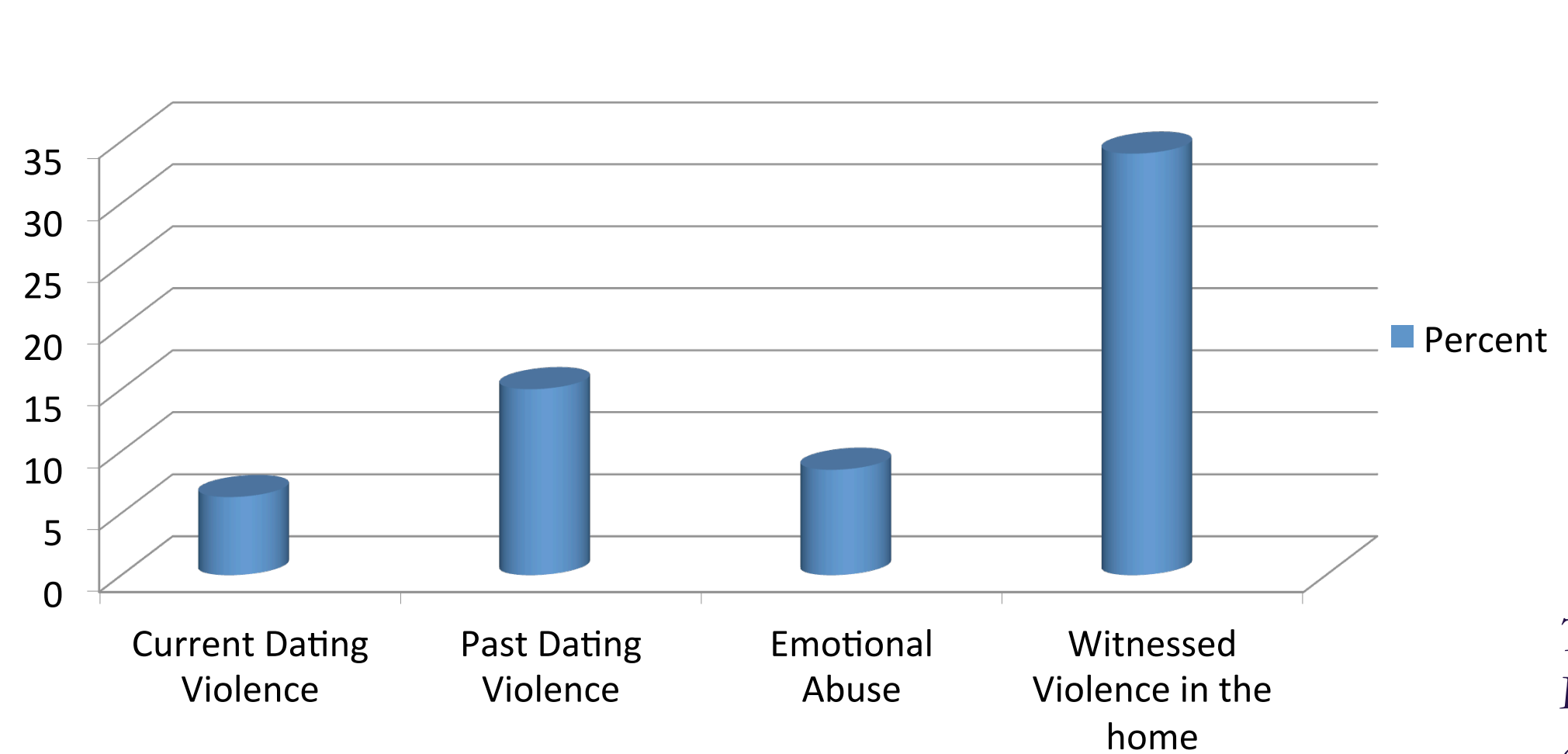


Results

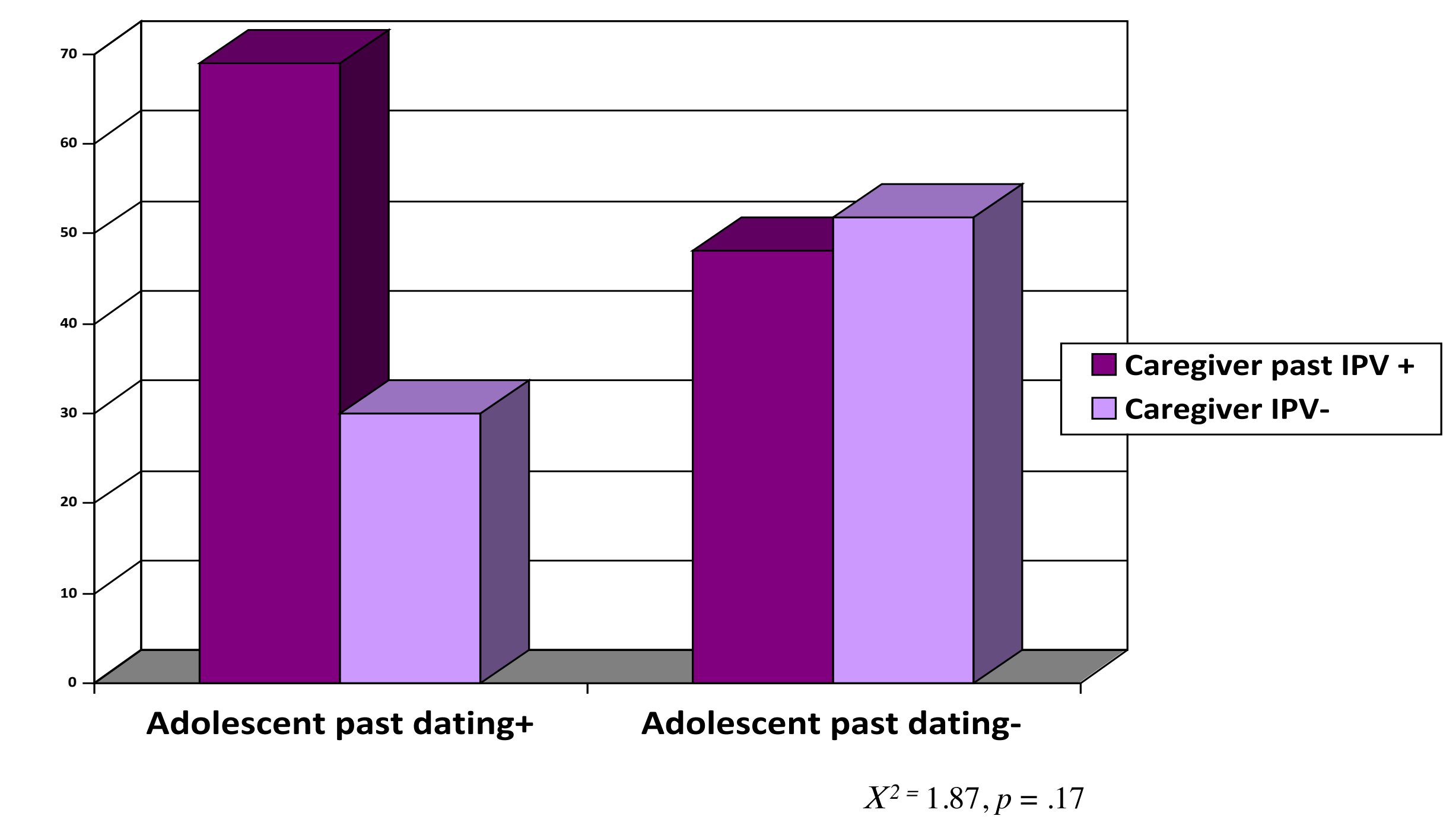
Exposure to Violence: Female Caregivers ($N = 1230$)



Exposure to Violence: Adolescents ($N = 141$)



Exposure to Violence: Matched Adolescent-Female Caregiver Pairs ($N = 69$)



Detailed Assessments Adolescents ($n = 36$)

Adolescent's BMI was significantly and positively associated with adolescent's dating violence physical victimization ($r = .35^*$), psychological perpetration ($r = .47^{**}$), physical perpetration ($r = .38^*$), PTSD symptoms ($r = .36$), maternal reports of inconsistent discipline ($r = .43^*$) and maternal concerns of adolescent's internalizing and externalizing behaviors (r^2 s = .41* and .43*, respectively).

* $p < .05$, ** $p < .01$

Somatic symptoms, such as headaches, dizziness, fatigue, were compiled in a total symptom score.

Two regressions were conducted:

1) **Psychological and physical dating violence victimization and PTSD were regressed on total somatic complaints;**

--Psychological and physical dating violence victimization explained 49% of the variance in total somatic complaints,

$F(2, 33) = 15.81, p < .01$

--PTSD symptoms explained an additional 14% of the variance in total somatic complaints,

$F(1, 32) = 11.45, p < .01$

--Both PTSD symptoms and physical victimization were unique predictors in the final model

2) **Psychological and physical dating violence perpetration were regressed on total somatic complaints;**

--Psychological and physical dating violence perpetration explained 30% of the variance in total somatic complaints,

$F(2, 33) = 7.09, p < .05$

--PTSD symptoms explained an additional 25% of the variance in total somatic complaints

$F(1, 32) = 17.71, p < .01$

--PTSD symptoms were the only unique predictor in the final model

Future Directions

◆ Female caregivers and adolescents tolerate and even welcome violence assessment and safety planning within a pediatric setting. Of note, single item screenings may be less sensitive when compared with more detailed assessments of violence exposure.

◆ Common pediatric complaints, such as generalized somatic concerns and higher BMI may be associated with stressors in the adolescent's life, including dating violence exposure, as well as other common presenting concerns (internalizing/externalizing) seen within pediatric practices. Symptoms of PTSD may be associated with an array of other presenting pediatric somatic concerns and should be regularly assessed.

References

- McCloskey, L., Lichter E., Ganz, M., Williams, C., Gerber, M., Sege, R. et al. (2005). Clinical practice: Intimate partner violence and patient screening. *Academic Emergency Medicine*, 12(8), 712-722.
- Centers for Disease Control and Prevention. (2006). Physical dating violence among high school students - United States, 2003. *MMWR*; 55:532-535. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5519a3.htm>

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